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| REQUEST FOR PRIVATE MEDICAL INFORMATION For use of this form, see AR 40-66; the proponent agency is the OTSG | | 1. Date (YYYYMMDD) | | | | | | | | | | | | | | | | | | | | |
| 2. Patient's Name and SSN. | 3. Medical Treatment Facility (Name and Location) | | | | | | | | | | | | | | | | | | | | | |
| 4. Reason for Request. To determine suitability for criminal investigative responsibilities in accordance with AR 195-3, Acceptance, Accreditation, and Release of United States Army Criminal Investigation Command Investigative Personnel. | | | | | | | | | | | | | | | | | | | | | | |
| 5. Private Medical Information Sought (Specify dates of hospitalization or clinic visits and diagnosis, if known) Any diagnosis or treatment of a mental disorder to include: <table style="width: 100%; border: none;"> <tr> <td style="width: 35%;">(a) Substance Related Disorders</td> <td style="width: 10%; text-align: center;">___ Yes</td> <td style="width: 10%; text-align: center;">___ No</td> <td style="width: 45%;"></td> </tr> <tr> <td>(b) Mood Disorders</td> <td style="text-align: center;">___ Yes</td> <td style="text-align: center;">___ No</td> <td></td> </tr> <tr> <td>(c) Anxiety Disorders</td> <td style="text-align: center;">___ Yes</td> <td style="text-align: center;">___ No</td> <td></td> </tr> <tr> <td>(d) Eating Disorders</td> <td style="text-align: center;">___ Yes</td> <td style="text-align: center;">___ No</td> <td></td> </tr> <tr> <td>(e) Personality Disorders</td> <td style="text-align: center;">___ Yes</td> <td style="text-align: center;">___ No</td> <td></td> </tr> </table> Any prescriptions for psychotropic medications? ___ Yes ___ No Is the soldier permanently non-deployable for any reason? (Explain) ___ Yes ___ No Does soldier have a permanent profile? (Explain) ___ Yes ___ No Does soldier have normal color vision? ___ Yes ___ No (Note: If not, a physician's statement that the soldier can differentiate between colors of red, amber, and green, must be attached.) | | | (a) Substance Related Disorders | ___ Yes | ___ No | | (b) Mood Disorders | ___ Yes | ___ No | | (c) Anxiety Disorders | ___ Yes | ___ No | | (d) Eating Disorders | ___ Yes | ___ No | | (e) Personality Disorders | ___ Yes | ___ No | |
| (a) Substance Related Disorders | ___ Yes | ___ No | | | | | | | | | | | | | | | | | | | | |
| (b) Mood Disorders | ___ Yes | ___ No | | | | | | | | | | | | | | | | | | | | |
| (c) Anxiety Disorders | ___ Yes | ___ No | | | | | | | | | | | | | | | | | | | | |
| (d) Eating Disorders | ___ Yes | ___ No | | | | | | | | | | | | | | | | | | | | |
| (e) Personality Disorders | ___ Yes | ___ No | | | | | | | | | | | | | | | | | | | | |
| 6. Requestor's Name, Title, Organization and SSN. | | | | | | | | | | | | | | | | | | | | | | |
| FOR USE OF MEDICAL TREATMENT FACILITY ONLY | | | | | | | | | | | | | | | | | | | | | | |
| 7. Check applicable box. <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved (State reason for disapproval) | | | | | | | | | | | | | | | | | | | | | | |
| 8. Summary of Private Medical Information Released. | | | | | | | | | | | | | | | | | | | | | | |
| 9. Signature of Approving Official. | 10. Date (YYYYMMDD) | | | | | | | | | | | | | | | | | | | | | |